MEDICARE SECONDARY PAYER

INFORMATION FOR EMPLOYERS

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MEDICARE SECONDARY PAYER

A MESSAGE FROM THE ADMINISTRATOR

Medicare is a Federal health insurance program for people 65 or over and for certain disabled people.

Some people who can get Medicare also have coverage under an employer group health plan. Employers who sponsor health benefits for their employees and employees' families need to know which health plan pays first for people with Medicare, Medicare or the employer plan. Sometimes Medicare pays second.

As a sponsor of health plans that cover people who may have Medicare, you need to know when Medicare is secondary payer to your employer plan. This booklet explains the Medicare secondary payer (MSP) law and what you need to do to comply with MSP requirements.

This booklet also explains a new information collection procedure now required by Federal law. Under the new law, the Health Care Financing Administration (HCFA), the Social Security Administration (SSA), and the Internal Revenue Service (IRS) will match information from their records to determine likely cases in which Medicare should be secondary payer to another insurer. HCFA will then contact employers to confirm whether employees and their families who have Medicare also have group health coverage under an employer plan. This booklet explains what you will be required to do when you are contacted.

Assuring that the Medicare secondary payer rules are followed will enable your plan to process claims correctly. This in turn will prevent administrative difficulties and lost time and money from mistaken payments and recovery actions by Medicare.

We appreciate your cooperation and hope you find this booklet useful.

Gail R. Wilensky

Gail R. Wilensky, Ph.D.
Administrator

EMPLOYER GROUP HEALTH PLANS AND THE MEDICARE SECONDARY PAYER PROGRAM

Some people who have Medicare also have group health coverage. Usually, Medicare is their primary payer, which means that Medicare pays first on their health care claims. Sometimes, the other plan must pay first. In that case, Medicare is the secondary payer.

Medicare secondary payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. (The private insurance industry generally talks about "coordination of benefits" when assigning responsibility for first and second payment.)

The terms "Medicare supplement" and "Medicare secondary payer" are sometimes confused. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the primary payer. Medicare supplement policies typically pay for the expenses that Medicare does not pay because of deductible or coinsurance amounts or other limits under the Medicare program. An employer cannot offer or subsidize a Medicare supplement policy where the law makes Medicare the secondary payer.

Until 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation (including black lung benefits) or veterans benefits. Since 1980, new laws have made Medicare the secondary payer for several additional categories of people. The additional categories of people for whom Medicare is the secondary payer are described below.

Federal law takes precedence over conflicting State law and private contracts. Thus, for the categories of people described below, Medicare is secondary payer regardless of state law or plan provisions. These Federal requirements are found in Section 1862(b) of the Social Security Act (42 U.S.C. Section 1395y(b)). Applicable regulations are found at 42 C.F.R. Part 411 (1990). You should verify that your group health plan is in conformity with these Federal requirements. This booklet is meant to explain the MSP requirements but is not a legal document. The official Federal requirements are contained in the relevant laws, regulations and rulings.

WHO DOES MSP AFFECT?

Medicare is now secondary payer to some employer group health plans (EGHPs) for services provided to the following groups of Medicare beneficiaries:

- The "working aged."
- People with permanent kidney failure.
- Certain disabled people.

As used in this booklet, an EGHP is:

- a plan that provides health care, either directly or indirectly through insurance or otherwise,
- provided to employees, former employees, or the families of employees or former employees, and
- contributed to or sponsored by an employer or an employee organization.

An EGHP includes those plans where employees pay all the costs.

The term *plan* includes insurance plans, prepaid arrangements, and self-insured plans. A plan can be any arrangement between one or more parties for the provision of health care. The arrangements may be oral or written.

Working Aged

The "working aged" are employed people aged 65 or over and people aged 65 or over with employed spouses of any age who have EGHP coverage because of their or their spouse's current employment. The term *employed* includes self-employed people.

Medicare is secondary payer to EGHPs for the "working aged" where **either**:

- a single employer of 20 or more employees is the sponsor or contributor, **or**
- two or more employers are sponsors or contributors, and at least one of them has 20 or more employees.

Medicare is secondary payer regardless of how many employees actually enroll in the plan.

For EGHPs with more than one sponsoring or contributing employer, there are three possibilities:

- Where all of the employers have less than 20 employees, Medicare is primary payer for all working aged people enrolled in the plan because the plan is not subject to the MSP provisions.
- Where all of the sponsoring or contributing employers have 20 or more employees, Medicare is secondary payer for all working aged people enrolled in the plan.
- Where some of the sponsoring or contributing employers have 20 or more employees and some have less than 20, Medicare is secondary payer for all working aged people enrolled in the plan. There is one exception: an EGHP may choose not to cover those working aged people enrolled through an employer with fewer than 20 employees. In that case, Medicare would become primary payer for specifically identified working aged people enrolled through an employer with fewer than 20 employees.

People With Permanent Kidney Failure

Medicare is secondary payer to EGHPs for up to 12 months for beneficiaries who have Medicare solely because of permanent kidney failure. This requirement applies both to those with permanent kidney failure who have their own coverage under an EGHP and to those covered under an EGHP as dependents.

The period during which the EGHP is primary begins with the earlier of:

- The month in which the person begins a regular course of renal dialysis; or,
- The first month in which the person becomes entitled to Medicare, if he or she receives a kidney transplant without first beginning dialysis.

After the period of up to 12 months expires, Medicare is primary payer and the plan is secondary payer.

The HCFA publication "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services" contains more information about Medicare and kidney disease. You can get a free copy from the Social Security Administration, HCFA, or the Consumer Information Center, Department 59, Pueblo CO 81009 (refer to publication number 603V).

Disabled People

Medicare is secondary payer for people under age 65 who have Medicare because of disability (other than those with permanent kidney failure) and who are covered under a large group health plan (LGHP) as an employee, employer, self-employed person, a business associate of an employer, or a family member of any of these people. The term employee here includes both those who are actively working despite their disability (such as disabled Medicare beneficiaries engaged in a trial work period) and those who are not actively working but whom the employer treats as employees. Medicare decides whether or not a person is an employee in accordance with regulations and instructions.

An LGHP is a plan to provide health care to employees, former employees, the employer, business associates of the employer, or their families, where **either**:

- A single employer or employee organization (such as a union) with 100 or more employees is the sponsor or contributor,
  or
- If two or more employers or employee organizations are sponsors or contributors, at least one of them has 100 or more employees. The plan cannot exempt persons enrolled through an employer who has fewer than 100 employees.

The term LGHP includes plans in which employees pay all the costs.

EMPLOYER RESPONSIBILITIES UNDER MSP

Employers have a number of important responsibilities under the MSP law:

- To identify those individuals to whom the MSP requirements apply.
- To provide for proper primary payments when the law makes Medicare the secondary payer.
- To assure that there is no discrimination against employees and employees' spouses aged 65 or over, people who suffer from permanent kidney failure, and disabled Medicare beneficiaries for whom Medicare is secondary payer.

Working Aged

If you are an employer with 20 or more employees, your EGHP must not discriminate against employees aged 65 or over, or employees' spouses aged 65 or over, whether or not they have Medicare. The benefits offered to these people under your plan must not differ in any way from the benefits offered to people who do not have Medicare. Your EGHP must be primary payer for those benefits in MSP situations, and must not take into account working aged people's entitlement to Medicare. EGHPs must not, for example:

- fail to make primary payment, or make a smaller payment, on behalf of someone for whom Medicare is secondary payer,
- terminate coverage of employees and employees' spouses aged 65 or over, either (1) because they have become entitled to Medicare, or (2) if younger employees and spouses are treated differently,
- refuse to allow employees and employees' spouses aged 65 or over to enroll, or to reenroll, on the same basis as younger employees and spouses,
- impose limitations on benefits, exclusions of benefits, or reductions in benefits on those aged 65 or over that are not applicable to younger people who are enrolled in the plan, or
- impose higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness conditions for those aged 65 or over than are applicable to those under 65 who are enrolled in the plan.

You must inform employees and employees' spouses who are entitled to Medicare that they may reject coverage under the plan and choose Medicare as their primary payer. If they reject coverage under the employer plan, you

may not offer them or subsidize a plan intended only to supplement Medicare's benefits. Employer plans may, however, offer them coverage for items and services for which Medicare provides no benefits (for example, prescription drugs and eyeglasses).

Beneficiaries who reject the employer plan may purchase Medicare supplemental (Medigap) coverage from a source other than the employer. The employer may not purchase or subsidize an individual supplemental policy for the employee or family member.

People With Permanent Kidney Failure

For people who have Medicare only because of permanent kidney failure, during the 12 months in which an EGHP must pay first:

> The EGHP must be primary payer for them and not take into account their entitlement to Medicare based on permanent kidney failure. The EGHP must not, for example, fail to make primary payment or make a smaller payment on behalf of someone for whom Medicare is secondary payer. In addition, the EGHP must not discriminate against them because they have permanent kidney failure. The benefits provided must not differ in any way from the benefits provided to persons who do not have permanent kidney failure. This nondiscrimination requirement applies both during and after the period when Medicare is secondary payer, and whether or not a person is entitled to Medicare.

For all people with permanent kidney failure, with or without Medicare, both during and after the 12 month period, the plan may not, for example:

- refuse to allow an individual with permanent kidney failure to enroll, or to reenroll, in the plan, on the same basis as persons who do not have permanent kidney failure,
- fail to cover routine kidney dialysis services or kidney transplants at the same level as other services covered by the plan,
- impose limits on benefits, reduce benefits, or impose exclusions on enrollees who have permanent kidney failure that are not applicable to enrollees who do not have permanent kidney failure, or
- impose higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness conditions than are applicable to those who do not have permanent kidney failure.

People With Disability

An LGHP must not discriminate against disabled Medicare beneficiaries for whom Medicare is secondary payer. This means that it must not treat these people differently from other enrollees because they are disabled and have Medicare.

For example, with respect to these disabled Medicare individuals, an LGHP must not:

- fail to make primary payment, or make a smaller payment on behalf of someone for whom Medicare is secondary payer,
- terminate coverage on the basis of entitlement to Medicare,
- provide for different benefits, or a different level of benefits, on the basis of entitlement to Medicare, or
- charge a higher premium than it charges to other enrollees in the plan.

Employers must offer disabled Medicare beneficiaries the opportunity to reject the LGHP's coverage. In that case, Medicare becomes their primary payer, and the employer must not offer them or subsidize supplemental (Medigap) coverage, except for items and services wholly uncovered by Medicare (for example, prescription drugs and eyeglasses). However, beneficiaries who reject the LGHP may purchase Medicare supplemental coverage from a source other than the employer.

MAKING MSP WORK

The health insuring organizations under contract to pay Medicare claims (Medicare carriers and intermediaries) are responsible to deny claims for primary benefits when Medicare is secondary payer. These contractors are also responsible for informing providers, employers, insurers and beneficiaries about MSP and how it works. Staff members from Medicare contractors give talks on MSP to hospital groups, insurance associations, beneficiary advocacy organizations and others. A representative of a Medicare contractor in your area would be happy to talk to your organization about MSP or any other Medicare issue you would like to discuss.

Contractors collect information before paying Medicare claims to avoid costly and time-consuming recovery of Medicare mistaken payments. For example, they may call employers, insurers, claims administrators, or hospitals. When a contractor has reason to believe that a claim should be paid first by another payer, it generally withholds payment while it investigates whether Medicare is secondary.

Sometimes, after a Medicare claim is paid, a Medicare contractor gets new information that indicates Medicare made a primary payment by mistake. Based on this new information, the contractor seeks to recover the mistaken Medicare payment. If the party the contractor determines responsible for the primary payment disputes that determination and does not refund the money, the contractor refers the case to HCFA. HCFA reviews the case. If HCFA agrees with the contractor's determination, it attempts to resolve the dispute with the other payer.

If agreement on recovery cannot be reached at this stage, HCFA may refer the case to the Department of Justice for legal action. The law authorizes the Federal government to collect double damages from any party which is responsible for making primary payment but which fails to do so.

HCFA may also report EGHPs that fail to follow MSP rules—these are called "nonconforming group health plans"—to the Internal Revenue Service (IRS). IRS is required to impose a tax on the employers or employee organizations that contribute to those plans. The tax is equal to 25 percent of all the contributions they made to all group health plans during the year. This tax provision is found in Section 5000 of the Internal Revenue Code (26 U.S.C. Section 5000).

EMPLOYER REQUIREMENTS UNDER THE MSP DATA MATCH PROVISIONS

Data Match

In late 1989, Congress enacted a law to provide HCFA with better information about Medicare beneficiaries' health insurance. The new law authorizes the IRS, the Social Security Administration (SSA), and HCFA to share certain information that each agency has about whether Medicare beneficiaries or their spouses are working. The process for sharing this information is called the *Data Match*. The purpose of the Data Match is to identify situations where another insurance may be primary to Medicare.

Employer Contact

The Data Match will identify employers of beneficiaries for whom employer coverage, if available, is likely to be primary to Medicare. The law requires that HCFA contact these employers to confirm coverage information. A Medicare contractor designated by HCFA will begin contacting employers in late 1990. The designated contractor will provide details about the Data Match and the special toll-free telephone number for responding to specific questions about the Data Match.

Your Responsibilities As An Employer

The HCFA contractor will provide each employer with information from the Data Match, including the names and social security numbers of employees, and spouses of employees, when either or both have Medicare. HCFA will be asking for information about employer health coverage that each of these people had, such as:

- names and addresses of the health plans,
- periods of employment
- type of health coverage
- numbers of people employed.

The law requires each employer to respond within 30 days to the HCFA contractor's request for information.

Employer Penalties

You may be assessed a civil monetary penalty of $1,000 for **each** worker for which an inquiry concerning health coverage was made, if:

- You do not respond within 30 days, or
- You give inaccurate information.

Where to Obtain Assistance

If you have questions about Medicare Secondary Payer requirements or your responsibilities under the Data Match, write to:

U.S. Department of Health and Human Services
Health Care Financing Administration
Bureau of Program Operations, 300 ME
6325 Security Boulevard
Baltimore, Maryland 21207

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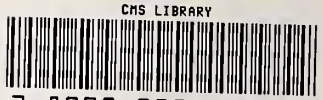
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